7018 Elmwood Avenue – 2nd Floor
Philadelphia, PA 19142

PHYSICAL EXAMINATION FORM * TO BE COMPLETED BY A PHYSICIAN

This certifies that Mr. /Ms. (Patient's name) _____ has been examined for occupational placement with your Company for the following:

Date of Examination: _____
Blood Pressure: _____ Height: _____ Weight: _____

Tuberculosis (TB) PPD Screening 2 Steps: *(every 2 years by Mantoux method, if positive X-ray should be done)*
Step 1: 1st Date Done: _____ 1st **Date Read:** _____ **Result:** _____
Step 2: 2nd Date Done: _____ 2nd **Date Read:** _____ **Result:** _____

If Positive, Chest X-Ray Date Done: _____ **Result:** _____
Recommendation: _____
_____

I have found ( ) indication ( ) no indication which might present a possible hazard to the health of consumers or other employees.
Other applicable health related comments or observation, if any: __ none
_____
_____
_____

Patient is __ clear OR __ not clear of communicable disease to provide personal care, companionship, and homemaking services including food handling to clients who may have existing communicable disease and/ or to clients at risk of contracting communicable disease due to age or general health. The patient is able to provide these services __ with OR __ without reasonable accommodations. Recommended accommodations or restrictions, if any:
__ None _____

Signed: _____ Date: _____/_____/_____
Physician
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (_____) _____ - _____ E-mail: _____

Patient/Caregiver Name: _____
Date of Examination: _____

Communicable disease status is as follows:
Tuberculosis: ___ Patient has tested positive in the par OR

___ Patient has reported possible recent exposure AND
___ Patient shows no current signs of active disease OR
___ Patient tested, Date Tested: _____
___ Patient tested, Date Read: _____
___ X-ray completed, Date _____ OR
___ Patient completed course of treatment date _____ OR
___ Patient showed signs of active disease and was referred for treatment

Caregiver Acknowledgment Initial: _____
German ___ Vaccine or infection history
Measles ___ No history or vaccination OR
(Rubella): ___ Unknown
Hepatitis A: ___ Vaccine or infection history outside of 45 days of examination
___ No history or vaccination OR
___ Unknown
Chicken Pox ___ Vaccination or infection history
Shingles ___ No history or vaccination OR
(Varicella): ___ Unknown
Hepatitis B: ___ vaccination series not required due to first responder OSHA status please check any/all other statements below which are also true of this patient:
___ Antibody testing revealed immunity in this caregiver
___ HBV vaccination series previously completed
___ Vaccination series in progress, will complete series by: Date: _____
___ Vaccination series was declined by this caregiver
___ Vaccine is not recommend in this patient for medical reasons
__ None

_____
Licensed Healthcare Practitioner Signature, Print name here:
_____
_____
Address
_____
_____ Telephone: _____